2025 - 2026

Employee Benefit Guide

Photo by Gordon Campbell

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Medicare Part D - Prescription Drug Information:
If you (and/or your dependents) are covered by Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 46 and 47 for more details.

Something NEW to think about!

invest529

- **Tax advantages:** Earnings on your accounts grow free from federal tax when used for qualified education expenses. Depending on your state of residence, you may be entitled to additional tax advantages.
- **Low Fees**: There's no online application fee, no annual maintenance fee and no withdrawal fee for qualified education expenses — and Invest529 administrative fees are among the lowest in the nation. Get started with just $10.
- **Flexible Uses:** Accounts can be used to fund qualified education expenses at schools nationwide and overseas. These accounts can be used at public or private universities, graduate, vocational and private or religious K-12 schools, apprenticeships, and student loan repayment.

We forget!

- **Wellness Credit for County Employees**
  - Provide Human Resources with a note from your provider showing you were seen for your annual wellness visit and you can receive 2 hours of paid leave as a *Thank you* for taking care of you!
  - Work with your supervisor to find the best time to use your 2 hours.
  - This is an annual benefit.
- **Leverage the pre-tax deductions** by enrolling in the Flexible Spending Accounts and/ or the Dependent Care Account with Flores.
- **Are you taking prescriptions on a monthly basis?**
  - Use the 90 - day prescription program through your insurance.
  - The price for a 90 - day prescription is usually cheaper than paying monthly (see page15 for more information).
- **Enroll in Anthem's Engagement Package 200**
  - Once enrolled you can earn up to $200 by completing activities outlined in the program.
  - Further information can be found on page 12.

Health & Wellness

At times, we may think about others, before we start to think about ourselves. It is important that we make the time to ensure we are on top of our health and wellness.

- Schedule your annual physical
- Keep follow-up appointments
- Follow through with tests that you discuss with your provider
- Ensure your mental health is up to par. There is nothing wrong with speaking to someone to discuss issues that you may be having or stresses in your life.
- Find ways to decompress and relax. Schedule a spa day, find 30 minutes per day for **JUST YOU!**

Wondering where you can find assistance to better your Health & Wellness?

- Anthem EAP
  FAQ page: www.co.accomack.va.us/departments/human-resources/faq/anthem-eap
  Phone: 800-346-5484
  EAP Login Page: www.anthem.com/employer/employee-benefits-programs/services
- Community Services Board (CSB): www.escsb.org
- Eastern Shore Rural Health: www.esrh.org
- Mental Health: www.mentalhealth.gov
- National Suicide Prevention Lifeline: suicidepreventionlifeline.org/
- Riverside Physicians: www.riversideonline.com
- Substance Abuse & Mental Health Services Administration: www.samhsa.gov/find-help/national-helpline
- Wellbeing: www.takingcharge.csh.umn.edu
- Wellbeing (Free Course): www.drlauriesantos.com/science-well-being
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Accomack County is not affiliated with any of the above listed agencies, organizations, and/or websites. As the employee, it is your responsibility to complete your research on an organization prior to making an appointment.

Benefits Overview

The County of Accomack, VA is proud to offer a comprehensive benefits package to eligible, full-time employees who work 30 hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical, dental, vision).

ATTENTION OUTSIDE AGENCIES: The insurance rates provided by Accomack County are accurate in terms of the overall premiums. However, the split between employer and employee pertain specifically to County employees. Contact your agency's **payroll or benefits specialist** for questions related to the employee share of premiums.

Benefits Offered

- Medical
- Dental
- Vision
- Flexible Spending Accounts
- Life Insurance
- Flexible Spending Accounts
- Employee Assistance Program
- Legal Plan
- Identity Theft Monitoring
- Aflac Products

Eligibility

You and your dependents are eligible for The County of Accomack benefits on the first of the month following your date of hire if your start date is on or between the 1st and the 14th of the month. If your start date is after the 15th of the month, benefits will begin the first of the month following 30 days of employment. Life benefits will became effective the first of the month following your date of employment for all eligible employees.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age, or County of Accomack, VA eligible dependents.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

Benefits YOU can enroll in on your own

- **Phone:** 888-567-0540
- **Website:** https://www.virginia529.com/invest/invest529
- **Invest529 FAQ's:** https://www.virginia529.com/resources/faqs/
- **Blog Link:** https://www.virginia529.com/blog/
- **Getting Started:** https://www.virginia529.com/invest/getting-started/

Benefits through Payroll Deduction

There are multiple benefits that are available through payroll deduction to County employees. You will be provided a list of those benefits on this page along with resources and information for each benefit.

AFLAC offers policies for Cancer insurance, Accident insurance and Critical Illness insurance
Our representative is Charles Bono
Phone: (757) 999-0232
Email: charlesbono@gmail.com

- A flexible spending account, or FSA, is a benefit where employees can contribute a set amount from their paycheck to help offset medical expenses
- Full-time employees can set aside pre-tax money into an account to be reimbursed for eligible dependent childcare expenses for their child or children under 13 years of age or for a dependent of any age that lives in your household that is incapable of self-care
- Contact your HR and/or benefits representative

- Legal Shield & ID Shield offers legal and identity services for employees. Legal Shield gives employees access to a lawyer 24 hour a day, 7 days a week, and 365 days a year. ID Shield overs protection and assistance with identity theft.
- Our representative is Rob Vest.
  Phone: (703) 945-3988
  Email: robvest@gmail.com

- Lincoln Financial Group offers an additional 457 retirement plan for the County of Accomack full-time employees. Employees can have money added to their 457 plan every pay period. You can make changes to your deductions as needed.
- Our representative is Sharon Ryan
  Phone: (757) 873-3331
  Email: Sharon.ryan@lfg.com

- Optional Life Insurance is available to all full-time Accomack County employees to purchase additional life insurance for themselves, spouse and/or children.
- Please see page 32 for further information regarding optional life.

Invest529®

Save Today for a Brighter Tomorrow

Invest529®

Want to learn more? Visit Virginia529.com to:

- Explore the **Smart Savers Academy** and learn about saving for your child's future from the comfort of your home. Get education savings answers from industry experts through live webinars and an on-demand video library
- Narrow down your investment options using the **Portfolio Selection Assistant**
- Use the **College Savings Estimator, Cost of Waiting Calculator and Financial Aid Calculator** to determine your future higher education costs and plan your saving strategy
- Review the underlying assets for each of **Invest529's investment options** and review their Portfolio performance

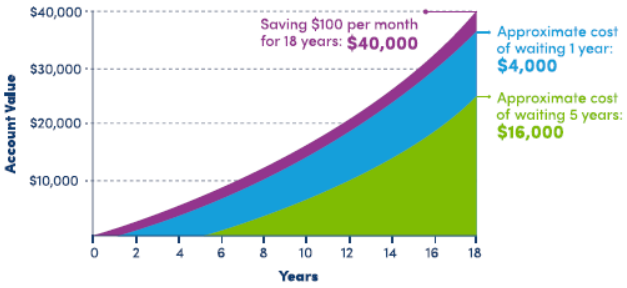
Want to win $529 toward an Invest529 account?

Visit **Virginia529.com/win** to read the terms and conditions, and enter for your chance to win!

What is a 529 Plan?

A 529 plan is a tax-advantaged way to save for higher education. 529 plans may also be used to save and invest for K-12 tuition, in addition to college and certain career training costs. The earlier you start, the more your savings can grow.

Cost of Waiting[1]



[1]This chart is for illustrative purposes only and is not intended to reflect actual performance of any specific investment. Assumes interest rate of 6.25 percent compounded monthly. The value of your Invest529 account will vary depending on market conditions and the performance of the investment option you select, and it may be more or less than the amount you deposited. You could lose money – including the principal you invest – or not make money if you invest in one of these programs. Past performance of investments is not an indicator of future returns.

Choose Your Path

Invest529 can be used to pay for qualified higher education expenses beyond tuition, including:

Higher Education
Tuition, fees, meals, room & board, textbooks, supplies and more

K-12
Tuition at private, public and religious schools

Registered Apprenticeship Programs
Fees, supplies and required equipment

Student Loan Repayment
Amounts paid on qualified student loans

Why Save with Invest529?

Invest529's award-winning program can help you get started with as little as $10, and you choose how much and how often to contribute in the future. Reach your goals faster and put your savings on autopilot with automated contributions from your bank account or your paycheck.

Low Fees

There's no online application fee, no annual maintenance fee and no withdrawal fee for qualified higher education expenses — and Invest529 administrative fees are among the lowest in the nation.

Tax Advantages

Earnings on your accounts grow free from federal tax when used for qualified higher education expenses. Plus, Virginia taxpayers can deduct up to $4,000 per account, per year from their Virginia state income taxes.

Flexibility

Accounts can be used to fund qualified higher education expenses at schools nationwide and overseas.

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website/Email
Medical	Anthem	800-331-1476	www.anthem.com
Dental	Anthem	800-331-1476	www.anthem.com
Vision	Anthem	866-723-0515	www.anthem.com
Employee Assistance Program	Anthem	800-346-5484	www.anthemEAP.com
FSA	Flores	800-532-3327	www.flores247.com
Accident, Critical Illness, Cancer/ Specified-Disease Insurance	Aflac	Chuck Bono 757-999-0232	www.aflac.com
Basic Life Insurance	Virginia Retirement System/Securian	800-441-2258	www.securian.com
Optional Life Insurance	Virginia Retirement System/Securian	800-441-2258	www.securian.com
457(b) Retirement Plan	Lincoln Financial Group	757-873-3331	www.LincolnFinancial.com/ Retirement

Open Enrollment Point of Contact List

Employee or Group	Point of Contact	Phone	Email
ANPDC Employees	Sandy Taylor	757-787-2936, ext.117	staylor@a-npdc.org
Board of Supervisors Retirees Partner Agencies *not* listed above	Priscilla Justis	757-787-5714	pjustis@co.accomack.va.us
Current County Employees	Jenifer Ward	757-787-5710	jward@co.accomack.va.us or AskHR@co.accomack.va.us
ES Public Library Employees	Janet Justis	757-787-3400	director@espl.org
Sheriff Department Employees	Jamie Collins	757-787-1131	jcollins@co.accomack.va.us
Social Services Employees	Wendy Linton	757-787-5385	wendy.linton@dds.virginia.gov

Medical Benefits

Administered by Anthem | www.anthem.com | 1-800-331-1476

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way - especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through the County of Accomack.

The County of Accomack offers you a choice of two (2) PPO medical plans. With the PPO, you may select where you receive your medical services. If you use in-network providers, your costs will be less.

	Plan Summary In-Network Benefits	
	Key Care Plus 20/20% $4,000	Key Care Plus 15/20% $3,500
	In-Network	In-Network
Lifetime Benefit Maximum	Unlimited	Unlimited
Annual Deductible	$0 single / $0 family	$0 single / $0 family
Annual Out-of-Pocket Maximum (includes deductible)	$4,000 single / $8,000 family	$3,500 single / $7,000 family
Coinsurance	20%	20%
Doctor's Office		
Primary Care Office Visit	$20 copay	$15 copay
Specialist Office Visit	$40 copay	$35 copay
Preventive Care	No charge	No charge
Diagnostic Test (X-ray, blood work)	Lab - No charge in lab or office setting X-Ray - 20% in office setting	Lab - No charge in lab or office setting X-Ray - 20% in office setting
Imaging (CT/PET scan, MRI)	$300 copay in outpatient hospital setting	$200 copay in outpatient hospital setting
Prescription Drugs		
Retail - Tier I (30-day supply)	$15 copay	$15 copay
Retail - Tier II (30-day supply)	$50 copay	$50 copay
Retail - Tier III (30-day supply)	$85 copay	$85 copay
Specialty	20% up to $300 maximum	20% up to $300 copay
Mail Order - Tier I (90-day supply)	$30 copay	$30 copay
Mail Order - Tier II (90-day supply)	$125 copay	$125 copay
Mail Order - Tier III (90-day supply)	$213 copay	$213 copay

Medical Benefits (Continued)

Administered by Anthem | www.anthem.com | 1-800-331-1476

	Plan Summary In-Network Benefits	
	Key Care Plus 20/20% $4,000	Key Care Plus 15/20% $3,500
	In-Network	In-Network
Hospital Services		
Emergency Room (Facility Services)	$300 copay	$300 copay
Inpatient	$300 copay per day to a maximum of $1,500	$300 copay per day to a maximum of $1,500
Outpatient Surgery	$300 copay	$300 copay
Ambulance Service	20%	20%
Mental Health Services		
Inpatient Services	$300 copay per day to a maximum of $1,500	$300 copay per day to a maximum of $1,500
Outpatient Services	Office Visit - $20 copay Other Outpatient - $150	Office Visit - $15 copay Other Outpatient - $150
Substance Abuse Services		
Inpatient Services	$300 copay per day to a maximum of $1,500	$300 copay per day to a maximum of $1,500
Outpatient Services	Office Visit - $20 copay Other Outpatient - $150	Office Visit - $15 copay Other Outpatient - $150
Other Services		
Maternity Services	Global physician fees - $300 per pregnancy Inpatient- $300 per day to a maximum of $1,500	Global physician fee - $300 per pregnancy Inpatient- $300 per day to a maximum of $1,500
Muscle Manipulation Services (based on setting)	$20 or $40 copay; up to 30 visits per year	$15 or $35 copay; up to 30 visits per year
Physical, Occupational and Speech Therapy Services (setting will determine cost)	$20 or $40 copay; up to 30 visits per year for physician	$15 or $35 copay; up to 30 visits per year for physician
Skilled Nursing	$300 copay per day to a maximum of $1,500; up to 150 days per year	$300 copay per day to a maximum of $1,500; up to 150 days per year

Employees who receive an annual wellness visit will receive 2 hours of paid leave per year, courtesy of Accomack County. Just provide proof of the date of your annual exam to Human Resources.

Dental Benefits

Administered by Anthem

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the County of Accomack dental benefit plan.

BASIC PLAN		
Services	**In-Network**	**Out-of-Network**
Annual Deductible	$50 per person; $150 family limit	$50 per person; $150 family limit
Annual Benefit Maximum	$1,000	$1,000
Preventive Dental Services (cleanings, exams, x-rays)	100%	80%
Basic Dental Services (fillings, root canal therapy, oral surgery)	80% after deductible	80% after deductible
Major Dental Services (crowns, bridges, dentures, repairs)	Not covered	Not covered
Orthodontia Services	Not covered	Not covered

MAJOR PLAN		
Services	**In-Network**	**Out-of-Network**
Annual Deductible	$50 per person; $150 family limit	$50 per person; $150 family limit
Annual Benefit Maximum	$1,500	$1,500
Preventive Dental Services (cleanings, exams, x-rays)	100%	80%
Basic Dental Services (fillings, root canal therapy, oral surgery)	80% after deductible	80% after deductible
Major Dental Services (crowns, dentures, repairs)	50% after deductible	50% after deductible
Orthodontia Services (adults and dependents children)	50% to $1,000 lifetime maximum	50% to $1,000 lifetime maximum

Vision Benefits - Major Plan

Administered by Anthem Blue Cross and Blue Shield

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Your coverage from a Blue View Vision Plan doctor

Service	**In-Network** (any Blue View Vision Plan provider)	**Out-of-Network** (any qualified non-network provider of your choice)
Eye Exam	Included under the medical plan	Included under the medical plan
Lenses — once per calendar year		
Single Vision Lenses	$25 copay	Up to $25 reimbursement
Lined Bifocal Lenses	$25 copay	Up to $40 reimbursement
Lined Trifocal Lenses	$25 copay	Up to $55 reimbursement
Frames — once every 12 months	$130 allowance then 20% off balance	Up to $45 reimbursement
Contact Lenses — once per calendar year if you elect contacts instead of lenses/frames		
Allowance	Conventional: $130 allowance then 15% off balance; Disposable: $130 allowance	Up to $105 reimbursement
Medically Necessary	Covered in full	Up to $210 reimbursement

Anthem
And Its Affiliate HealthKeepers, Inc.

Earn up to $200 per year making strides towards good health!

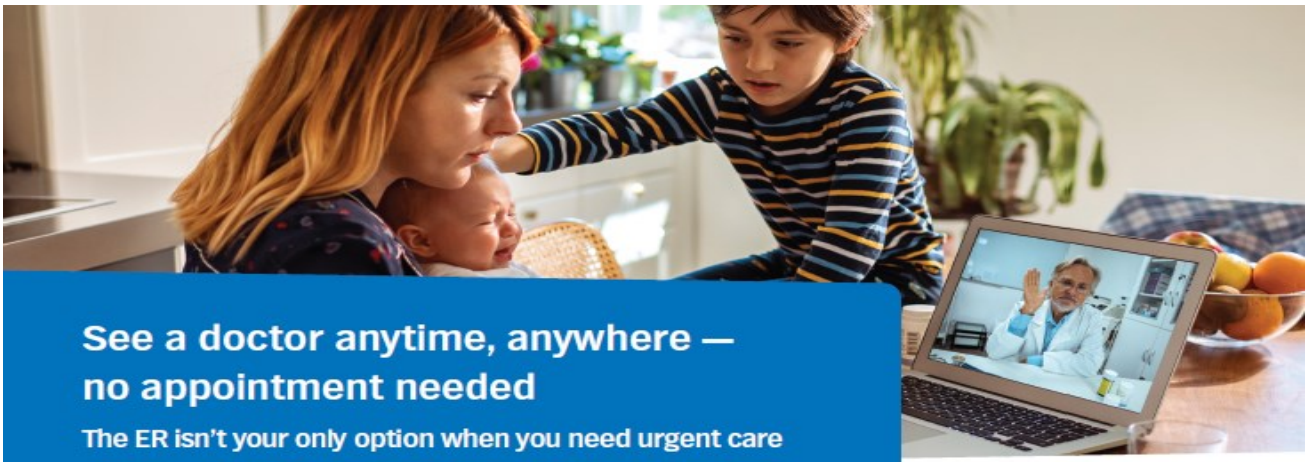
Engagement Package 200 - Focus on your well-being and earn rewards!

Your whole life matters, and we want to reward you for taking care of it. The Wellbeing Solutions program, sponsored by the County of Accomack, connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you complete any of the activities listed below, you will earn rewards to put toward electronic gift cards for select retailers. You choose the activities you would like to complete to receive the maximum of $200 in rewards. Don't wait, use your Sydney Health app or visit anthem.com to learn more.

Activity Type	Activities	Amount
Digital & wellness activities Rewards are added to your account as you complete activities on the Sydney Health app or on **anthem.com.**	Log in to your Anthem account	$5
	Connect a fitness or lifestyle device	$5
	Complete a health assessment and receive tailored health recommendations	$20
	Complete action plans around eating healthy, weight management, and physical activity	Up to $25 ($5 per action plan)
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Complete Well-being Coach digital daily check-ins[1]	Up to $20 ($4 per milestone)
	Update your contact information	$10

Activity Type	Activities	Amount
Preventive care Complete your annual screenings or wellness visits. Rewards are added to your account after your claim is processed (may take up to 60 days).	Have an annual preventive wellness exam or well-woman exam with your doctor	$25
	Get an annual cholesterol test[2]	$20
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Have an annual eye exam[3]	$25
	Get an annual flu shot	$20

Activity Type	Activities	Amount
Condition management Rewards are added to your account as you meet benchmarks or complete a program.	ConditionCare: Work one on one with your health coach and earn rewards for participating in and completing the program[4]	Up to $50 ($20/$30)
	Building Healthy Families: Help your family grow and thrive through the Sydney Health app and earn rewards for completing certain activities[5]	Up to $40 ($10/$10/$10/$10)
	Well-being Coach – Weight Management: Receive one-on-one coaching by phone as you complete your goal to earn a reward[6]	$25
	Well-being Coach – Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward[7]	$25



See a doctor anytime, anywhere — no appointment needed

The ER isn't your only option when you need urgent care

Why virtual care?

Help is available 24/7	Affordable care option	Reliable care you can trust
Fast doctor visits through your phone, tablet, or computer — no appointments or waiting rooms	Virtual visits cost significantly less than a trip to the emergency room[1]	Manage your urgent care needs and receive expert advice, treatment plans, and prescriptions[2]

What can virtual doctors treat?

Virtual doctors can typically treat conditions and symptoms including:[2]

- Colds
- Sore throats
- Headaches
- Mild fevers
- Stomach aches
- Uncomplicated urinary tract infections (UTIs)
- Care management for certain chronic conditions

As part of your treatment plan, your virtual doctor can also:

- Prescribe certain medications.
- Recommend specialists.
- Order lab tests.
- Tell you if it's time to seek care in person.
- Recommend over the counter medications or treatments.

If you think you are experiencing a life-threatening emergency or your health is in serious jeopardy, you should always call 911 or go to the emergency room (ER) immediately. However, if you need nonemergency care quickly, but your primary care doctor isn't available, it's important to know you have options besides the ER.

Are you ready to try a virtual visit?

Next time you're not feeling well, telehealth may be able to help.

Download the Sydney Health℠ app today

Use the Sydney Health℠ app for a virtual visit with a doctor 24/7. Video call, text, or chat with a doctor who can help you feel better — no appointment required.

Use your phone's camera to scan this QR code.

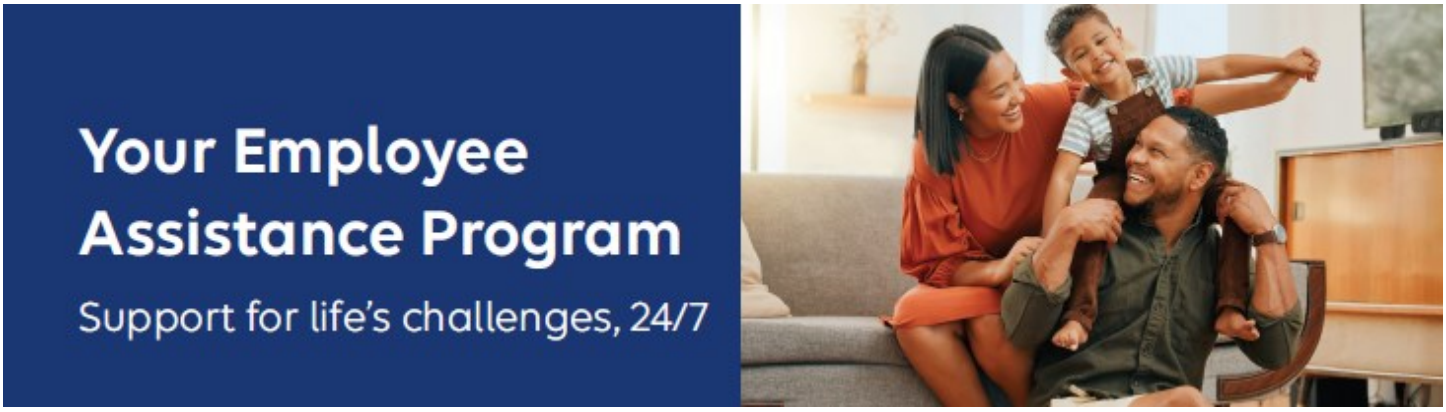
You can also ask your primary care doctor if they offer telehealth visits.

Employee Assistance Program

Administered by Anthem

Accomack County provides all full-time and part-time employees with an Employer-Paid Employee Assistance Program through Anthem. Your Employee Assistance Program (EAP) is here to help you and your household members meet life's challenges - big or small. If you need support, your EAP website has articles, podcasts, online seminars, and other resources that can help you feel more cared for, confident, and protected.

Check out some of the services offered - at no cost to you:



Counseling and mental health

- Get 4 free visits for in-person or virtual counseling per person in your household, per issue each year.[2]

Work-life resources

- Find information on career, parenting, and balancing work and family.
- Find high-quality child, elder, and pet care.
- Receive special discounts on a range of products and services, including food, travel, and clothing.

Identity theft support

- Register to get help with identity monitoring and theft resolution to minimize or recover from the effects of identity theft.

Self-improvement resources

- Log in to take self-assessments, access the Guidance to Care tool, and get a list of EAP resources specific to your needs.
- Use Emotional Well-being Resources to connect with one-on-one coaching and self-help digital tools.

Legal and financial resources

- Book a no-cost consultation and receive a discounted rate from participating local attorneys on continued legal services.[3]
- Explore an online library of legal resources, forms, and essential documents.
- Have unlimited phone consults with a financial professional and access online financial calculators and budgeting tools.

24/7 crisis support

- Get in-the-moment support when experiencing a personal crisis.
- Find help with navigating resources and getting support if you're impacted by a tragedy or natural disaster.

Get the help you need, 24/7

- Visit **anthem.com/EAP** and log in with company name: **Accomack County**
- Call your EAP at **800-346-5484** for help with questions.

Skip the pharmacy with home delivery

Save time and effort filling your regular prescriptions

Set up home delivery through CarelonRx Mail for the prescriptions you take long-term† for conditions like high blood pressure, diabetes, heart disease, or asthma. You'll receive your medications at your door and enjoy the convenience of not having to visit the pharmacy.

With home delivery, you can count on:

Convenience. Medications are delivered directly to your home or any location you choose.

- Manage your prescriptions with the Sydney℠ Health app or at **anthem.com**.
- Expect first-time home delivery orders to take about two weeks and refills to take 3 to 5 days.
- Set up reminders and automatic refills, too.

Safety. All orders are checked by a licensed pharmacist before they ship. Discreet packaging is:

- Tamperproof
- Weatherproof
- Temperature controlled, if needed

Peace of mind. You're less likely to miss a dose and more likely to stay on track with the treatment your doctor prescribed when you switch to home delivery.* Trained pharmacists can also answer your questions and help you 24/7.

Hassle-free service. CarelonRx Mail will contact your doctor to order a new, 90-day prescription if you need one. If a medication preapproval is needed, the home delivery team will reach out to you for consent before shipping your medication.

Savings. Many medications cost less when you fill a 90-day supply instead of three 30-day supplies. Shipping is always free.

Start home delivery now with these steps

1. Visit the *Pharmacy* page on **anthem.com**, choose the *Pharmacy* tab on the Sydney Health app, or scan the QR code with your phone's camera. Register your member account if you haven't already.
2. Choose **Request a New Prescription.**
3. Type in the prescription you'd like delivered.
4. Under the name and cost of your prescription, select **Request a New Prescription.**
5. Fill in any blank fields, such as shipping address, payment method, and prescriber.
6. First-time requestors will need to select **Continue to Medical Profile.**
7. Verify any allergies or health conditions, then select **Continue to Submit Order.**

We're here to help

Call CarelonRx Mail at **833-320-1180** or use the live chat feature on Sydney Health or **anthem.com**.

Save money

with SpecialOffers and discounts

As part of your health plan, you qualify for discounts on products and services that help promote better health and well-being. These discounts are available through SpecialOffers, which can help you save money while taking care of your health.

Vision, hearing, and dental

Eyewear

Glasses.com® and 1-800 CONTACTS®

Shop for the latest brand-name frames at a fraction of the cost of similar frames from other retailers. You also can receive additional savings on orders of $100 or more, plus no-cost shipping and returns.

EyeMed

Take advantage of discounts on new glasses, nonprescription sunglasses, and eyewear accessories.

LASIK

Premier LASIK Network

Save on LASIK when you choose any featured Premier LASIK Network provider.

TruVision

Save on LASIK eye surgery at over 1,000 locations.

Hearing

NationsHearing®

Receive hearing screenings and in-home service at no additional cost. You can also receive hearing aids at a discounted rate.

Hearing Care Solutions

Receive no-cost hearing exams and discounts on hearing aids. Hearing Care Solutions has 3,100 locations and eight manufacturers. They also offer a three-year warranty, batteries for two years, and unlimited visits for one year.

Amplifon

Save on top-quality care and receive ongoing service and support for your hearing aids.

Dental

RefreshaDent

Save on premium dentures sent direct to your home. You can receive a 50% discount on a lifetime warranty. This program includes a lifetime digital record of your dentures for easy replacement.

Anthem

Fitness and Health

Fitness

Active&Fit Direct™

Choose from thousands of participating gyms nationwide with no long-term contracts or annual fees, or get fit at home with access to 12,000+ on-demand workout videos at no cost.

Fitbit®

Work toward your fitness goals with Fitbit trackers and find smartwatches that fit your lifestyle and budget.

Garmin®

Discover discounts available on select Garmin wellness devices.

Husk Wellness

GlobalFit, by Husk Wellness, offers discounts on gym memberships, fitness equipment and technology, nutrition and mental health services, and virtual wellness solutions.

Health

Ahara

With a personalized nutrition plan, you can improve your health by discovering key nutrients your body needs along with hidden health risks. This includes a personalized meal plan tailored to your health goals and symptoms.

ChooseHealthy®

Find discounts on acupuncture, chiropractic, massage, podiatry, physical therapy, and nutritional services. You also have discounts on fitness equipment, wearable health trackers, and health products such as vitamins and nutrition bars.

LifeMart®

Receive deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services, yoga classes, sports gear, and vision care.

▷ **Learn more about SpecialOffers**

Log in to **anthem.com**, choose **Care**, and select **Discounts.**

Family and home

Family

23andMe®

Save on health and ancestry kits to learn about your wellness, ancestry, and more.

WINFertility®

Save up to 40% on infertility treatment. WINFertility helps make quality treatment more affordable.

Home

Nationwide® pet insurance

Receive discounts when you enroll through your company or organization. Additional savings are available when you enroll multiple pets.

ASPCA® Pet Health Insurance

Find reduced rates on pet insurance and choose from three levels of care, including flexible deductibles and custom reimbursements.

Medicine and treatment

Medicine

Puritan's Pride®

Choose from a large selection of discounted vitamins, minerals, and supplements.

Allergy Control Products and National Allergy Supply™

Save on select doctor-recommended products, such as allergy-friendly bedding, air purifiers and filters, and asthma products. Some orders qualify for no-cost ground shipping within the contiguous U.S.

Treatment

The Living Well Courses

Choose one of the online wellness programs and save on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or address alcohol or substance dependence.

BREVENA

Enjoy a discount on BREVENA skin care creams and balms for smooth, rejuvenated skin from head to toe.

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Employee Enrollment Application
For 100+ employee groups
Virginia

Anthem And Its Affiliate HealthKeepers, Inc.

AnthemLife

PPO health care plans, including dental and vision coverage, are insurance products offered by Anthem Blue Cross and Blue Shield (Anthem); HMO health care plans are health maintenance organization products offered by HealthKeepers, Inc. (HealthKeepers); Life and disability plans are insurance products offered by Anthem Life Insurance Company (Anthem Life).

Instructions:

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.
Please complete electronically or in blue or black ink only.

Application completed for (check company that applies)

- ☑ Anthem Blue Cross and Blue Shield
- ☐ HealthKeepers, Inc.
- ☐ Anthem Life Insurance Company

Employer name	Group no.	Subsection
County of Accomack	005050	

Section 1: Employee information

Last name	First name	M.I.	Social Security no.* (required)

Birthdate (MM/DD/YYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner – If available through your employer.	

Employee email address

Employment status	Hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time		

Primary Care Physician (PCP) name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Section 2: Reason for application – Select one

- ☐ New enrollment
- ☐ Annual open enrollment (not applicable to life and disability)
- ☐ New hire
- ☐ Rehire – Rehire date: (MM/DD/YYYY)
- ☐ Marriage – Date of marriage: (MM/DD/YYYY)
- ☐ Birth of child
- ☐ Add dependent (Fill in section 4)
- ☐ Loss of eligibility for other coverage – Date previous coverage ended: (MM/DD/YYYY)
- ☐ COBRA – Select qualifying event
  - ☐ Left employment
  - ☐ Reduction in hours
  - ☐ Death
  - ☐ Medicare
  - ☐ Loss of dependent child status
  - ☐ Divorce or legal separation
  - ☐ Covered employee's Medicare entitlement

  Qualifying event date: (MM/DD/YYYY)
- ☐ Waiver (To decline ALL coverage skip to section 7.)

*Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 3: Type of coverage

Medical coverage — Check company(ies) and write in product that applies. Application completed for:

☐ Anthem Blue Cross and Blue Shield — Product name: _____

☐ HealthKeepers, Inc. — Product name: _____ Point of service (POS)

Member medical coverage — select one:

☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + one child ☐ Employee + children ☐ Family ☐ No coverage

Flexible Spending Account (FSA) coverage — More than one plan may be selected, depending on employer offerings.

☐ Healthcare FSA (excluded if you have an HSA plan)
☐ Limited-Purpose FSA (for dental and vision services)
☐ Dependent Care FSA
☐ Commuter Parking
☐ Commuter Transit
☐ No FSA coverage at this time

Dental coverage

☐ Prime Essential Choice ☐ Complete Essential Choice
☐ Other: High Low

Member dental coverage — select one:

☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + one child ☐ Employee + children ☐ Family ☐ No coverage

Vision coverage

☐ Exam Only ☐ Full Service ☐ Other: _____

Member vision coverage — select one:

☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + one child ☐ Employee + children ☐ Family ☐ No coverage

Life and disability coverage *NOT AVAILABLE TO COUNTY EMPLOYEES*

If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.

☐ Basic Life
☐ Basic Life and Accidental Death and Dismemberment
☐ Basic Dependent Life
☐ Optional Supplemental/Voluntary Life and Accidental Death and Dismemberment . . . . . $_____ (employee amount)
☐ Optional Supplemental/Voluntary Dependent Life Spouse or Domestic Partner . . . . . $_____ (spouse or domestic partner amount)
☐ Optional Supplemental/Voluntary Dependent Life Child . . . . . $_____ (child amount)
☐ Voluntary Accidental Death and Dismemberment . . . . . $_____ (employee amount)
☐ Voluntary Accidental Death and Dismemberment Family Plan (Spouse or Domestic Partner and Child coverage)
☐ Voluntary Accidental Death and Dismemberment Spouse or Domestic Partner Only (no Child coverage)
☐ Voluntary Accidental Death and Dismemberment Child Only (no Spouse or Domestic Partner coverage)
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income For employer use For Anthem Life use $_____	Occupation	Life and disability class no. For employer use For Anthem Life use

*Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 4: Coverage information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. If available through your employer, an eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Spouse or Domestic Partner last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant or spouse or domestic partner ☐ Other If other, what is relationship? ____________
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ **Yes** ☐ **No** **If yes, please enter:** ____________			

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant or spouse or domestic partner ☐ Other If other, what is relationship? ____________
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ **Yes** ☐ **No** **If yes, please enter:** ____________			

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant or spouse or domestic partner ☐ Other If other, what is relationship? ____________
PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No	
Does this dependent have a different address? ☐ **Yes** ☐ **No** **If yes, please enter:** ____________			

*Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 5: Prior and other group coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If yes, give name: ____________________

Medicare ID no.	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date: ______ (MM/DD/YY)
Medicare Part D ID no.	Medicare Part D carrier		Part D effective date (MM/DD/YYYY)

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan? ☐ Yes ☐ No

If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policyholder name	Dates (if applicable) (MM/DD/YY)
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:

*Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 6: Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem/HealthKeepers/Anthem Life as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 31 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from Anthem/Healthkeepers /Anthem Life; or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- For Anthem Blue Cross and Blue Shield and Healthkeepers only, eligible dependents are employee's spouse, domestic partner, or children younger than age 26, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild, domestic partner's child, foster child, or any other child for whom the employee has legal guardianship or court-ordered custody. Coverage for children will end on the last day of the month in which the children reach age 26.
- For Anthem Life Insurance Company only, eligible dependents are employee's spouse, domestic partner, or children younger than age 26, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or domestic partner's child. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of a child who cannot support himself or herself because of intellectual disability or physical handicap that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand all benefits are subject to conditions stated in the Group Contract and coverage document. ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.

In signing this application I represent that:

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

I certify each Social Security number listed on this application is correct.

I agree to receive emails with supplemental information, such as newsletters, to help me get the most out of my plan. I agree to provide Anthem/HealthKeepers/Anthem Life with my most up to date email address. I know I can opt out or change my mind at any time by contacting Anthem/HealthKeepers/Anthem Life.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem/HealthKeepers with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem/HealthKeepers with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem/HealthKeepers with a written request to revoke my authorization at any time.

Life and/or Disability enrollees: Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.

These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

Employee signature

X

Date (MM/DD/YYYY)

Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Critical Illness Insurance eligibility information:

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

*Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 7: Waiver/Declining coverage

Medical coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse or domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's or domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse or domestic partner covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Dental coverage

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse or domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's or domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse or domestic partner covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Vision coverage

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse or domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's or domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse or domestic partner covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Life, Accidental Death & Dismemberment (AD&D) and Disability coverage

***Life/AD&D** coverage declined for: ☐ Myself

Spouse, Domestic Partner and dependent coverage not available if life coverage is waived/declined.

Dependent Life coverage declined for: ☐ Spouse or domestic partner and dependents

Optional Supplemental/Voluntary coverage declined for: ☐ Myself

Optional Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse or domestic partner and dependents

Voluntary Short Term Disability coverage declined for: ☐ Myself

Voluntary Long Term Disability coverage declined for: ☐ Myself

Reason for declining coverage – check all that apply:

- ☐ Life/AD&D declined for religious reasons
- ☐ Do not elect to enroll in Dependent Life
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary coverage
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary Dependent Life coverage
- ☐ Do not elect to enroll in Voluntary Short Term Disability
- ☐ Do not elect to enroll in Voluntary Long Term Disability

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

Reset Form Save and Print

*Anthem/HealthKeepers is required by the Internal Revenue Service to collect this information.

Waiver of Group Health Benefits & Notice of Special Enrollment Rights

County of Accomack

(Employer Name)

Please complete the following:

Employee Name: _____ _____ _____
(Last) (First) (MI)

Employee Number: _____
(ID, Social Security or employee #)

For the plan year effective ___/___/___ I am waiving coverage for:
(MM/DD/YY)

☐ Myself
☐ Spouse/Domestic Partner
☐ Dependent (s) – Please list names: _____

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's/domestic partner's plan – name of carrier: _____

☐ Other coverage – name of carrier: _____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formerly CHAMPUS)
☐ Medicaid ☐ Employer-Sponsored Group Plan

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature of Employee Date of Signature

Return to your Employee Benefits Group Administrator Do Not Return to Anthem (AVA 1433)

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Flexible Spending Accounts

Administered by Flores | www.flores247.com | 1-800-532-3327

You can save money on your healthcare and/or dependent daycare expenses with an FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

YOUR STEPS TO SAVINGS!

1 REALIZE THE TAX SAVINGS

You can set aside pre-tax money into an account to be reimbursed for eligible medical expenses. Savings will depend on your tax bracket. For example, if you are taxed at 25% and you enroll for $3,200 you would save $800 in taxes.

2 ESTIMATE YOUR EXPENSES

Plan for your upcoming expenses and include your spouse and dependents, if eligible. A brief list of expenses can be found to the right. A comprehensive list of allowable expenses and an expense worksheet can be found at www.flores247.com.

Make sure to estimate your expenses carefully un-used funds will be forfeited if not used within the plan year if greater than the allowed carryover amount for Healthcare

THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) CAN REIMBURSE YOU FOR ELIGIBLE EXPENSES YOU OR YOUR ELIGIBLE DEPENDENTS INCUR THAT ARE NOT PAID BY YOUR EXISTING HEALTH CARE PLAN.

ELIGIBLE EXPENSES

- Medical co-payments, co-insurance and deductibles
- Routine wellness visits
- Prescription expenses
- Vision expenses (including eye exams, eyeglasses and contact lenses)
- LASIK surgery
- Dental expenses (excluding cosmetic procedures)
- Orthodontia payments
- Hearing expenses
- Over-the-counter Medications
- Menstrual Care Items
- COVID-19 Related PPE

YOUR STEPS TO SAVINGS!

1 **REALIZE THE TAX SAVINGS**

You can set aside pre-tax money into an account to be reimbursed for eligible dependent childcare expenses. Savings will depend on your tax bracket. For example, if you are taxed at 25% and you enroll for $5,000 you would save $1,250 in taxes.

2 **ESTIMATE YOUR EXPENSES**

Plan for your upcoming expenses. A brief list of expenses can be found to the right. A comprehensive list of allowable expenses and an expense worksheet can be found at www.flores247.com.

Make sure to estimate your expenses carefully unused funds will be forfeited if not used within the plan year.

THE DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) CAN REIMBURSE YOU FOR DAY CARE EXPENSES PROVIDED FOR YOUR DEPENDENTS SO THAT YOU (AND YOUR SPOUSE, IF YOU ARE MARRIED) CAN WORK. CARE MUST BE FOR A DEPENDENT CHILD UNDER AGE 13 OR A DEPENDENT OF ANY AGE THAT LIVES IN YOUR HOUSEHOLD THAT IS INCAPABLE OF SELF-CARE.

ELIGIBLE EXPENSES

- Preschools
- Before and after school care
- Day camps

INELIGIBLE EXPENSES

- Overnight camps
- Tuition / kindergarten & educational expenses
- Regular fees not applied to care of child

FLORES

FSA*Direct* ENROLLMENT FORM

PLEASE PRINT CLEARLY. USE ALL CAPITAL LETTERS.

GENERAL INFORMATION

Group: County of Accomack Plan ID: 1000797524

ID#

	Last	First
Name		

Address

City State Zip -

Phone ( ) - - E-Mail

Pay Frequency ○ Weekly ○ Bi-Weekly ◉ Semi-Monthly ○ Monthly Effective Date 6/1/2024

All enrollment elections made on this form are effective for the plan year beginning 06./01./2024 and ending 05./31./2025. No changes can be made to these elections once the plan year has begun unless you experience a family status change event. See your enrollment booklet for a list of these events. **Return the completed form to your Human Resources department.**

For Assistance Call 1-800-532-3327

MEDICAL SPENDING ACCOUNT INFORMATION

Minimum Annual Contribution: $120.00 Maximum Annual Contribution: $3,200.00

In the spaces provided below, indicate the amount you wish to contribute to the Medical Spending Account for the year and the amount to be deducted from each paycheck. Note: If your annual election does not equal your paycheck deduction multiplied by the number of payperiods left in the plan year, then your paycheck deduction amount will be adjusted accordingly.

Your Annual Election: Your Paycheck Deduction:

DEPENDENT CARE SPENDING ACCOUNT INFORMATION

Minimum Annual Contribution: $120.00 Maximum Annual Contribution: $5,000.00

In the spaces provided below, indicate the amount you wish to contribute to the Dependent Care Spending Account for the year and the amount to be deducted from each paycheck. Note: If your annual election does not equal your paycheck deduction multiplied by the number of payperiods left in the plan year, then your paycheck deduction amount will be adjusted accordingly.

Your Annual Election: Your Paycheck Deduction:

INSURANCE PREMIUM INFORMATION

In the spaces provided below, indicate the amount to be withheld from your paycheck for each listed insurance plan. If you are not participating in a plan, enter zero as your deduction amount for that plan. Lines labeled "Not Applicable" should be left blank.

Group Health P	N/A	
Dental Policy	N/A	
VIsion Policy	N/A	
Medical FSA	N/A	

PAYROLL AUTHORIZATION

I have read The Summary Plan Description provided by the above mentioned employer and hereby choose to participate as shown above. I agree to a per pay period reduction during the plan year referenced above for the amounts indicated. I understand that this election is binding for the plan year and that changes are only permitted in case of a change in family status or spouse's employment.

Employee Signature (Void if not signed) Date

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Group Basic Life Insurance

Administered by The Virginia Retirement System (VRS)
Underwritten by Minnesota Life Insurance Company—a Securian Financial company
www.securian.com | 1-800-441-2258 | P.O. Box 1193, Richmond, VA, 23218-1193

The County provides basic group term life insurance to employees through the Virginia Retirement System, and underwritten by Minnesota Life Insurance Company. This coverage is provided at no cost to the employee. For a natural death, the benefit is equal to the employee's pay (rounded to the next $1,000), and then doubled. For accidental death, the benefit amount will be equal to the life benefit. There is no maximum limitation on this benefit.

Eligibility

You are eligible for coverage if you are a full-time salaried:

- State employee
- An employee of a participating political subdivision
- Employees who work on a temporary or wage basis are not eligible

Amount of Coverage

The amount of your life and accidental death & dismemberment insurance coverage is equal to your annual salary rounded to the next highest thousand, then doubled.

Coverage Amount Examples

Salary	Rounded Salary	Insurance Amount
$9,100	$10,000	$20,000
$25,300	$26,000	$52,000
$24,000	$24,000	$48,000

Make sure to update or add your beneficiary!

Group Optional Life Insurance - Employee Paid

Administered by The Virginia Retirement System (VRS)
Underwritten by Minnesota Life Insurance Company - a Securian Financial company
www.securian.com | 1-800-441-2258 | P.O. Box 1193, Richmond, VA, 23218-1193

The following options are available to newly eligible employees without providing evidence of insurability (EOI):

- Optional life: Elect an amount in increments of 1-8x your salary up to a maximum of $800,000
- Spouse term life: If you elect coverage for yourself, your spouse will be eligible to receive a benefit equal to up to one-half your salary not to exceed $200,000
- Child term life: All coverage is guaranteed (amount based upon your optional life election).

EOI will be required for any amounts exceeding the guaranteed limit of $400,000 for the employee and $200,000 for a spouse, or if any coverage is applied for outside of your 31-day eligibility period. EOI is also required if you want to increase coverage after transferring to one state agency to another state agency.

Optional Coverages	
Employee	1-8 x salary up to a maximum of $800,000. Amounts over $400,000 will require underwriting (EOI)
Spouse	1/2 to 2x your salary up to a maximum of $400,000. Amounts over $200,000 will require underwriting (EOI)
Children	$10,000, $20,000 or $30,000. Children are eligible from 15 days old to maximum age
Accidental Death & Dismemberment	Your optional life elections will be matched with an accidental death & dismemberment benefit

Monthly Cost of Coverage

Optional Life - employee, retiree and spouse	
Age	Rate/$1,000
34 and under	$0.05
35-39	$0.06
40-44	$0.08
45-49	$0.14
50-54	$0.20
55-59	$0.33
60-64	$0.59
65-69	$1.06
70 and over	$2.06

Child term life		
Option	Coverage Amount	Rate
1	$10,000	$0.80
2	$20,000	$1.60
3	$30,000	$2.40

How much life insurance do I need? Check out this life calculator at - Lifebenefits.com/insuranceneeds

Enrollment Application for Virginia Retirement System Optional Group Life Insurance - Virginia Retirement System-39

securian FINANCIAL®

Minnesota Life Insurance Company - a Securian Financial company
Richmond Branch Office • 1051 E Cary Street • Suite 702 • Richmond, VA 23219-1193
1-800-441-2258 • Fax 804-644-2460

Employer code (5 digits)	Employer name	Employee's annual salary

1 - EMPLOYEE INFORMATION

Social Security number	Name (last, first, middle initial)	Date of birth (mo/day/yr)

Street address	City	State	Zip code

Sex ☐ Male ☐ Female	Marital status ☐ Married ☐ Single	Age	Employment date (mo/day/yr)	Payroll frequency

2 - ELECTION OF INSURANCE AMOUNTS

I wish to insure myself ☐ and ☐ my spouse and ☐ my child(ren).
Sign and date section 4, Payroll Deduction Authorization.

OPTIONAL INSURANCE AMOUNTS

Option	Employee	Spouse	Child(ren)
☐ 1	1 X Salary	.5 X Salary	$10,000
☐ 2	2 X Salary	1.0 X Salary	$10,000
☐ 3	3 X Salary	1.5 X Salary	$20,000
☐ 4	4 X Salary	2.0 X Salary	$30,000
☐ 5	5 X Salary	2.0 X Salary	$30,000
☐ 6	6 X Salary	2.0 X Salary	$30,000
☐ 7	7 X Salary	2.0 X Salary	$30,000
☐ 8	8 X Salary	2.0 X Salary	$30,000

If the option you elected will provide insurance of $400,000 or higher, you must complete an Evidence of Insurability form (EOI). Your spouse must also complete an EOI form if you elected options 2 through 8. Optional amounts of insurance in excess of $800,000 for an employee and $400,000 for a spouse are not provided. If you and your spouse are insured as employees under the Basic VRS Group Life Insurance Plan neither of you is eligible for coverage as a spouse. If you do not apply when you are first eligible to do so, or within 31 days immediately thereafter, you must complete an EOI for yourself and eligible dependents you subsequently elect to insure.

3 - DEPENDENT INFORMATION

See reverse side for definition of Eligible Dependents (eligibility must be verified by Employer's Representative).
How many children do you have who are less than 21 years of age? _____
How many children do you have who are age 21 to 25 and who are currently full-time students? _____
List information about your spouse and **youngest** child below:

Name (last, first, middle initial)	Relationship	Sex	Social Security number	Date of birth (mo/day/yr)
	Your Spouse	☐ Male ☐ Female		
	Youngest Child	☐ Male ☐ Female		

4 - PAYROLL DEDUCTION AUTHORIZATION	
I hereby authorize my Employer to deduct from my compensation the amount necessary to provide the insurance amounts indicated above. I understand that the deduction amount will change as my age and annual salary change.	
Signature X	Date signed

5 - STATEMENT BY EMPLOYER'S REPRESENTATIVE		
I certify that I believe the statements made herein are true and accurate, as disclosed by the records of this office, and the Social Security Number and Annual Salary are correct as entered.		
Employer's representative X	Title	Date signed

ELIGIBLE DEPENDENTS

The following persons are eligible to be insured under the Virginia Retirement System Optional Group Life Insurance Plan:

- the employee's spouse, and
- the employee's unmarried, natural, or legally adopted children* who are not self-supporting, and
- the employee's unmarried step-children* who live full-time with the employee in a parent-child relationship and can be claimed as a dependent on the employee's Federal income tax return, and
- any other children* if they are in the permanent court-ordered custody of the employee.

* Children 15 days old or older, but have not attained the age of 21, or have not attained the age of 25 if a full-time student in a accredited educational institution or of any age if such child is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who is chiefly dependent on the insured for financial support and maintenance.

Beneficiary Information

The employee can name more than one primary beneficiary to share in both Basic and Optional life insurance, or name a different beneficiary for each benefit. The employee is the beneficiary for the Optional Group Life Insurance on the employee's spouse and children.

DESIGNATION OF BENEFICIARY

VIRGINIA RETIREMENT SYSTEM
P.O. Box 2500 ◆ Richmond, VA 23218-2500
Toll-free 1-888-827-3847
Fax 804-786-9718
www.varetire.org

Clear Form

1. Social Security Number	
2. Employer Code	

PART A. MEMBER/RETIREE INFORMATION

3. Name (First, Middle Initial, Last)	**4. Are you retired?** ❑ Yes ❑ No
5. Address (Street, City, State and ZIP+4)	**6. Birth Date**

PART B. BENEFICIARIES FOR VRS BASIC GROUP LIFE INSURANCE

Check ONE:

❑ **I revoke any previous designations and elect payment of VRS basic group life insurance benefits to be made by order of precedence established by law.** If you check this box, **do not** complete the beneficiary information below. Continue to Part C. (Order of precedence is explained in the form instructions.)

❑ **I revoke any previous designations and elect payment of VRS basic group life insurance benefits to the beneficiaries designated below.** If you check this box, complete the beneficiary information below.

Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Name of Trust Organization			**Date of Trust**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Trustee or Organization Executive Officer**	

Are additional Basic Group Life Insurance beneficiaries listed on a VRS-2A continuation form?
❑ Yes ❑ No

PART C. BENEFICIARIES FOR VRS OPTIONAL GROUP LIFE INSURANCE

Complete this section only if you have optional group life insurance covering yourself.

Check ONE:

- ❑ **I revoke any previous designations and elect payment of VRS optional group life insurance benefits to be made by order of precedence established by law.** If you check this box, **do not** complete the beneficiary information below. Continue to Part D. (Order of precedence is explained in the form instructions.)
- ❑ **I revoke any previous designations and elect payment of VRS optional group life insurance benefits to the beneficiaries designated below.** If you check this box, complete the beneficiary information below; or:

  Check here ❑ if you want the beneficiaries for optional group life to be the same beneficiaries you designated in Part B for basic group life insurance. (If you check this box, you may leave Part C blank and VRS will pay optional life insurance benefits according to the designations made in Part B.)

Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Name of Trust Organization			**Date of Trust**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Trustee or Organization Executive Officer**	

Are additional Optional Group Life Insurance beneficiaries listed on a VRS-2A continuation form?
❑ Yes ❑ No

Social Security Number

PART D. BENEFICIARIES FOR VRS DEFINED BENEFIT MEMBER ACCOUNT RETIREMENT CONTRIBUTIONS/ BENEFITS

Check ONE:

- ❑ **I revoke any previous designations and elect payment of VRS defined benefit retirement contributions/benefits to be made by order of precedence established by law.** If you check this box, **do not** complete the beneficiary information below. Continue to Part E. (Order of precedence is explained in the form instructions.)
- ❑ **I revoke any previous designations and elect payment of VRS defined benefit retirement contributions/benefits to the beneficiaries designated below.** If you check this box, complete the beneficiary information below.

Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Name of Trust Organization			**Date of Trust**
Address (Street, City, State and ZIP+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Trustee or Organization Executive Officer**	

Are additional VRS Defined Benefit beneficiaries listed on a VRS-2A continuation form?
❑ Yes ❑ No

PART E. CERTIFICATION

Member Certification: I do hereby revoke all previous designations of primary and contingent beneficiaries, if any, and designate the beneficiary(ies) as indicated on this form to receive the proceeds of the basic and optional group life and accidental death and dismemberment insurance policies administered by VRS if I am covered under those policies, and to receive the accumulated retirement contributions/benefits to my credit in VRS at the time of my death. I do hereby direct that should I survive all of the above-named primary and contingent beneficiaries, any amount(s) which otherwise would have been payable to such beneficiary(ies) shall be paid in the order of precedence established by law and as listed in the instructions of this form or to such other beneficiary(ies) as I shall hereafter designate by written designation filed with the VRS Board of Trustees in accordance with its procedures. The right to change the beneficiary(ies) designation without the consent of said beneficiary(ies) is reserved. All information I provide in this document is true and I understand that any willful falsification of facts presented may result in prosecution as provided by law. (Persons holding a Power of Attorney, acting under a Guardianship, or acting as a Trustee may not make or change any beneficiary designation unless the relevant documentation specifically grants the authority to do so. Persons not holding such documents may not make or change any member’s beneficiary designation unless granted the authority to do so by court order.)

Member Signature ____________________ Date ____________

Social Security Number

INSTRUCTIONS FOR COMPLETING THE DESIGNATION OF BENEFICIARY

Complete this form to designate a beneficiary for VRS Basic and Optional Group Life Insurance and for your defined benefit retirement contribution account. It is only necessary to designate a beneficiary if you want payment to be made by means other than the order of precedence established by law. If you previously completed a VRS-2 and wish to change beneficiaries or now wish to choose the order of precedence, you must complete this form to revoke any prior designations.

Please read the information provided on this form to understand your options for designating a beneficiary. Additional information is provided in your *Handbook for Members,* which is available at www.varetire.org or from your human resources representative.

Order of Precedence

You may choose the order established by law to provide payment of your benefits or you may designate specific beneficiaries to receive your benefits in the event of your death. The order of precedence is as follows:

- To your spouse;
- *If no surviving spouse*, to the children* of the member and descendants of deceased children, per stirpes;
- *If none of the above*, to your parents equally or to the surviving parent;
- *If none of the above*, to the duly appointed executor or administrator of your estate;
- *If none of the above*, to your next of kin under the laws of the state where you reside at the time of your death.

  *Children means all children except stepchildren, foster children, minors who happen to be living with the member, and individuals raised by the deceased member as a "child."

Life Insurance Benefits

Your VRS Basic and Optional Group Life Insurance benefits will be paid by order of precedence unless otherwise indicated in Parts B and C of this form.

Defined Benefit Retirement Benefits

Death in Service:

If you are vested (have at least five years of service credit) and die while in service with a VRS-covered employer and your death is ***not*** work-related, VRS pays retirement benefits as follows:

- If no designation is made, or the death of all primary and contingent designated beneficiaries occurs prior to your death and another designation is not made, the beneficiary is determined by order of precedence.
- If you name your spouse, minor child(ren), or parent(s) as a beneficiary, or they are deemed the beneficiary by order of precedence, that person may receive a monthly benefit or may elect a refund of the contributions and accrued interest in your account to the exclusion of any other named beneficiary. The spouse will take precedence over a minor child, a minor child will take precedence over a parent.
- If the beneficiary named, or determined by order of precedence, is someone other than your spouse, minor child(ren), or parent(s), a refund of the contributions and interest credited to your account is paid.

If you are not vested and die while in service with a VRS-covered employer and your death is ***not*** work-related, VRS pays defined benefit retirement benefits in the form of a refund to your designated beneficiary.

If you die while in service with a VRS-covered employer, and your death ***is*** work-related, VRS pays defined benefit retirement benefits as follows regardless of whether or not you are vested:

- A refund of contributions and interest is paid to your designated beneficiary. If no designation is made, or the death of all of your primary and contingent designated beneficiaries occurs prior to your death and another beneficiary is not designated, the contributions and interest credited to your account are refunded to the beneficiary as determined by order of precedence.
- In addition to the refund of contributions and interest, a monthly benefit is paid to your surviving spouse for life. If you have no surviving spouse, the monthly benefit is paid to your minor child(ren) until age 18. If you have no minor child(ren), the benefit is paid to your parent(s) for life. All benefits are governed by and subject to the Virginia Retirement Act (*Code of Virginia Title 51.1*)

Death After Retirement:

If you die after your effective date of retirement and chose a payout option other than a Survivor Option, a refund of the contributions and interest that have not been paid to you as a monthly retirement benefit is refunded to your named beneficiary or, if no beneficiary designation is on file with VRS, to the first person qualifying by order of precedence.

If you die after your effective date of retirement and chose a Survivor Option, your monthly retirement benefit payment continues to the person you named as your contingent annuitant.

If you are retired, selected a survivor option and wish to change the name of the person you selected to receive the monthly benefit at the time of your death, contact VRS for further information. *This form cannot be used to change the contingent annuitant you designated at retirement*.

Death After Separation:

If you die after you have separated from employment in a VRS-covered position but before beginning to receive a monthly retirement benefit and you have not taken a refund of the contributions and interest credited to your account prior to your death, a refund of the contributions and interest credited to your account is paid to your named beneficiary; or if no beneficiary designation is on file, to the first person qualifying by order of precedence.

Other Key Points to Remember

1. This form is *not* used to designate a beneficiary for any defined contribution account funds that you may have as a part of your covered employment. Contact your defined contribution plan provider directly to designate beneficiaries.
2. This form cannot be used to designate a beneficiary for your spouse's or children's coverage under the Optional Life Insurance Plan because you are the beneficiary of those benefits.
3. If you name multiple primary beneficiaries, other than those established by law for death in service benefits, the proceeds will be split equally, unless you instruct otherwise in the Share % box for each beneficiary on this form. If you need to designate additional beneficiaries, list them on the Designation of Beneficiary – Continuation (VRS-2A) at the time you complete the VRS-2 and send both forms to VRS.
4. Complete the form using full names such as "Mary L. Doe" rather than "Mrs. John Doe."
5. If a **minor** (child less than 18 years of age) is named as beneficiary, a guardian for the financial estate of the minor must be appointed by the court before benefits can be paid.
6. If an **estate** is named as beneficiary, a probated will appointing an administrator or executor must be provided or the court must appoint an administrator or an executor before benefits can be paid.
7. If a **trust** is named as beneficiary, list the name of the trustee and the date that the trust agreement was completed. Do not submit a copy of the trust with this form. A copy will be requested when the claim for benefits is made.
8. Forms that have been altered cannot be accepted. If you make an error when completing this form, complete a new form.
9. *Beneficiary Types:* When you choose beneficiaries, you must indicate whether each beneficiary is a primary or contingent beneficiary.

   Primary: Person(s) to receive the death benefits payable upon your death.

   Contingent: Person(s) to receive the death benefits payable upon your death, if the primary beneficiary(ies) dies before you.

9. *Share %:* You may provide less than 100% share to an individual beneficiary and you may break down the shares designated for each benefit differently. Be sure your share percentages total 100% for each type of benefit.

Completing the Form

Part A. Member/Retiree Information

Enter your personal information in boxes 1 though 6 on page 1, and provide your Social Security number at the bottom of each subsequent page. The employer code is required in box 2 only if you are an active VRS member.

Part B. Designation of Beneficiary for VRS Basic Group Life Insurance

Check the appropriate box to indicate whether you wish to have payment of basic group life insurance be made by order of precedence or have the payment made to beneficiaries you designate.

If you choose to designate beneficiaries, enter each beneficiary's full name, Social Security number and complete address as well as whether the beneficiary is primary or contingent, the person's relationship to you, the percentage of life insurance to be paid to the person, and his or her birth date.

Part C. Designation of Beneficiary for VRS Optional Group Life Insurance

Check the appropriate box to indicate whether you wish to have payment of optional life insurance be made by order of precedence or have the payment made to beneficiaries you designate.

If you choose to designate beneficiaries that are different that the beneficiaries you designate for your basic group life insurance, enter each beneficiary's full name, Social Security number and complete address as well as whether the beneficiary is primary or contingent, the person's relationship to you, the percentage of life insurance to be paid to the person, and his or her birth date.

Part D. Designation of Beneficiary for Accumulated VRS Defined Benefit Retirement Contributions/Benefits

Check the appropriate box to indicate whether you wish to have payment of VRS retirement contributions/benefits be made by order of precedence or have the payment made to beneficiaries you designate.

If you choose to designate beneficiaries, enter each beneficiary's full name, Social Security number and complete address as well as whether the beneficiary is primary or contingent, the person's relationship to you, the percentage of retirement contributions/benefits to be paid to the person, and his or her birth date.

Part E. Certification

Sign and date the member certification. Remember to keep a copy of the completed form for your records before you send the form to VRS.

Also remember any Designation of Beneficiary – Continuation (VRS-2A) that you complete must be sent along with the Designation of Beneficiary (VRS-2). VRS must receive both forms in the same mailing.

DCP

Virginia Retirement System

DESIGNATION OF BENEFICIARY INSTRUCTIONS

HYBRID DEFINED CONTRIBUTION PLANS

Please provide all of the requested information for each designated beneficiary, including the date of birth and Social Security number, as this information will help MissionSquare Retirement locate your beneficiaries.

The primary beneficiary(ies) will receive your Hybrid Retirement Plan Defined Contribution plan assets upon your death. You may designate one or more persons as your primary beneficiary(ies). If none of your primary beneficiaries are alive at the time of your death, then the assets will be paid to the contingent beneficiary(ies) that you have designated. You may designate one or more persons as your contingent beneficiary(ies). Be sure to use whole percentages when designating multiple beneficiaries. If you have not designated any beneficiaries or if both the Primary and Contingent Beneficiaries are not alive at the time of your death, then the assets will be paid pursuant to the terms of the Plan Document as follows: unless otherwise directed on the Beneficiary Designation form, the beneficiary designation shall be deemed to be my surviving spouse, or if none, my children and descendants of my deceased children, per stirpes, or if none, my parents equally if both living, or if none, the duly appointed executor or administrator of my estate, or if none, the next of kin entitled to inherit under the laws of my domicile at the time of my death, as determined by the Virginia Retirement System.

To designate additional beneficiaries, (1) write "see attached sheet" on the primary and/or contingent beneficiary line(s) under "Name" and (2) attach and sign a separate piece of paper with your name, plan number, Social Security number, and additional beneficiary information.

Missing percentage(s) for all of your primary and/or contingent beneficiaries will result in equal allocation among beneficiaries. Beneficiary designations are invalid if percentages are given for every beneficiary, but they do not equal 100% or are expressed with fractions (e.g., 33 1/3%).

If you are naming a trust as your primary or contingent beneficiary, a complete copy of your entire trust document must be submitted with this form. MissionSquare will not be able to honor your beneficiary designation if the entire copy of your trust document is not included.

SPOUSAL CONSENT FOR MARRIED PARTICIPANTS

If you live in a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, or WI), your spouse is generally entitled to be the primary beneficiary for at least 50% of your account unless he or she consents to waive this right in the presence of a notary public.

Failure to meet community property state law requirements with respect to your beneficiary designation may result in your beneficiary designation being invalid, and the payment of benefits to someone other than your intended beneficiary(ies).

AUTHORIZATION

Once you have completed this form, sign it and submit the pages to MissionSquare. If this form is faxed (202-682-6439) to MissionSquare, please do not mail the original.

Please be aware that designations made on this form only apply to the defined contribution component of the Hybrid Retirement Plan and do not impact designations you may make for the defined benefit component, which you must do separately. Some provisions related to voluntary contributions and the associated employer match may differ for school division employees who have elected to use an employer-sponsored hybrid 403(b). For additional information, contact your human resources office.

To designate a beneficiary(ies) for the defined benefit component, you may complete and submit a Designation of Beneficiary (VRS-2) to VRS. The form is available at www.varetire.org. Be sure to keep a copy for your records.

DCP

Virginia Retirement System

DESIGNATION OF BENEFICIARY FORM

HYBRID DEFINED CONTRIBUTION PLANS | 1 OF 3

108043 — Hybrid 401(a) Cash Match Plan

307059 — Hybrid 457 Deferred Compensation Plan

Date (mm/dd/yyyy) __ __/__ __/__ __ __ __

NOTE: Beneficiary information can also be added, changed and deleted by accessing your account online at www.varetire.org or contacting an Participant Services associate at VRS-DC-PLAN1 (877-327-5261).

PARTICIPANT INFORMATION — *PROVIDE NAME/SOCIAL SECURITY NUMBER AS IT CURRENTLY APPEARS ON YOUR ACCOUNT.*

Social Security Number __ __ __-__ __-__ __ __ __

Email _____

Full Name of Participant

_____

LAST FIRST M.I.

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. Primary and contingent beneficiaries must separately total 100%. The number of primary or contingent beneficiaries you may name is not limited. Attach an additional sheet if necessary. Please see instructions.

BENEFICIARY DESIGNATION

Read the important beneficiary information in the form instructions before completing this section. **Please use whole percentages and be sure the percentages total 100%** when designating primary and contingent beneficiaries.

HYBRID 401(A) CASH MATCH PLAN | 108043

A. Primary Beneficiary(ies) — will receive your assets upon your death. The primary beneficiary information you indicate here will supersede previously submitted information and will be used by MissionSquare to determine the primary beneficiary(ies) entitled to all or a portion of your plan account.

PRIMARY BENEFICIAR(IES)

	Primary Beneficiary Name	Date of Birth (mm/dd/yyyy)	Relationship to You*	Social Security Number	% of Benefit
1		__ __/__ __/__ __ __ __		__ __ __-__ __-__ __ __ __	%
2		__ __/__ __/__ __ __ __		__ __ __-__ __-__ __ __ __	%
3		__ __/__ __/__ __ __ __		__ __ __-__ __-__ __ __ __	%

**The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.*

Total = 100%

B. Contingent Beneficiary(ies) — will receive your assets if there is no primary beneficiary(ies) living at the time of your death. The contingent beneficiary information you indicate here will supersede previously submitted information and will be used by MissionSquare to determine the contingent beneficiary(ies) entitled to all or a portion of your plan account.

CONTINGENT BENEFICIAR(IES)

	Contingent Beneficiary Name	Date of Birth (mm/dd/yyyy)	Relationship to You*	Social Security Number	% of Benefit
1		__ __/__ __/__ __ __ __		__ __ __-__ __-__ __ __ __	%
2		__ __/__ __/__ __ __ __		__ __ __-__ __-__ __ __ __	%
3		__ __/__ __/__ __ __ __		__ __ __-__ __-__ __ __ __	%

**The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.*

Total = 100%

Plan Number	Social Security Number	Name (Last, First, M.I.)	Date (mm/dd/yyyy)
108043 | 307059	___-___-_____	_____	__/__/_____

BENEFICIARY DESIGNATION (CONTINUED)

HYBRID 457 DEFERRED COMPENSATION PLAN | 307059

☐ *PLEASE CHECK HERE IF YOU WOULD LIKE TO DESIGNATE THE SAME PRIMARY AND CONTINGENT BENEFICIARIES THAT YOU LISTED ON PAGE 1 — YOU DO NOT NEED TO COMPLETE THIS SECTION.*

A. Primary Beneficiary(ies) — will receive your assets upon your death. The primary beneficiary information you indicate here will supersede previously submitted information and will be used by MissionSquare to determine the primary beneficiary(ies) entitled to all or a portion of your plan account.

PRIMARY BENEFICIAR(IES)

	Primary Beneficiary Name	Date of Birth (mm/dd/yyyy)	Relationship to You*	Social Security Number	% of Benefit
1	_____	__/__/_____	_____	___-___-_____	_____%
2	_____	__/__/_____	_____	___-___-_____	_____%
3	_____	__/__/_____	_____	___-___-_____	_____%

The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.* **Total = 100%

B. Contingent Beneficiary(ies) — will receive your assets if there is no primary beneficiary(ies) living at the time of your death. The contingent beneficiary information you indicate here will supersede previously submitted information and will be used by MissionSquare to determine the contingent beneficiary(ies) entitled to all or a portion of your plan account.

CONTINGENT BENEFICIAR(IES)

	Contingent Beneficiary Name	Date of Birth (mm/dd/yyyy)	Relationship to You*	Social Security Number	% of Benefit
1	_____	__/__/_____	_____	___-___-_____	_____%
2	_____	__/__/_____	_____	___-___-_____	_____%
3	_____	__/__/_____	_____	___-___-_____	_____%

The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.* **Total = 100%

SPOUSAL CONSENT — *ONLY APPLICABLE TO PARTICIPANTS RESIDING IN AZ, CA, ID, NV, NM, TX, WA, OR WI*

IF YOU LIVE IN THE COMMONWEALTH OF VIRGINIA, THIS SECTION IS NOT APPLICABLE.

Spousal Consent to Name a Non-Spousal Primary Beneficiary(ies): By signing below, I hereby voluntarily consent to the beneficiary designation made by my spouse and waive my designation as sole primary beneficiary. I understand that (1) the effect of this designation is to cause some or all of my spouse's death benefit to be paid to someone other than me; (2) each beneficiary designation is not valid unless I consent to it; and (3) my consent (signature) must be witnessed by a notary public.

Signature of Participant's Spouse _____ Date __/__/_____

Print Name of Participant's Spouse _____

Your request cannot be processed without a Notary Public Signature and Seal.

SPOUSAL CONSENT IS REQUIRED TO BE WITNESSED BY:

Notary Public

Subscribed and sworn before me this _____ day of _____ (month), 20__

Notary Signature _____

Commission Expiration Date __/__/_____

Registration Number _____

Seal Or Stamp

Plan Number	Social Security Number	Name (Last, First, M.I.)	Date (mm/dd/yyyy)
108043 | 307059	___-___-____	_____	__/__/____

REQUIRED PARTICIPANT SIGNATURE

This designation is effective when signed, dated and received by MissionSquare ("Service Provider") at the address below prior to the death of the participant. If I name more than one beneficiary in either category, the surviving beneficiaries in that category will share equally unless otherwise indicated. I have the right to change the beneficiary. If any information is missing, additional information may be required prior to recording my beneficiary designation. If my primary and contingent beneficiaries predecease me or I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan Document as follows: unless otherwise directed on the Beneficiary Designation form, the beneficiary designation shall be deemed to be my surviving spouse, or if none, my children and descendants of my deceased children, per stirpes, or if none, my parents equally if both living, or if none, the duly appointed executor or administrator of my estate, or if none, the next of kin entitled to inherit under the laws of my domicile at the time of my death, as determined by the Virginia Retirement System.

I have completed, understand and agree to all pages of this Beneficiary Designation form. I understand that the Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, the Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC website at: http://www.ustreas.gov/offices/eotffc/ofac.

Participant Signature _____ Date __/__/____

SEND ORIGINAL TO MISSIONSQUARE:

MissionSquare Retirement
Attn: Workflow Management Team
P.O. Box 96220
Washington, DC 20090-6220

Fax Number: **202-682-6439**

Website: www.varetire.org

Notes

Legal Notices

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Key Care Plus 20/20% $4,000 (Individual: 20% coinsurance and $0 deductible; Family: 20% coinsurance and $0 deductible)

Plan 2: Key Care Plus 15/20% $3,500 (Individual: 20% coinsurance and $0 deductible; Family: 20% coinsurance and $0 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 757-787-5710 or kcarmody@co.accomack.va.us.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protections Disclosure

The County of Accomack medical plans generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Anthem at 800-331-1476.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem at 800-331-1476.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility -

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=e n_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 Email:DHHS.ThirdPartyLiabl@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY:711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025 or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
County of Accomack, VA is committed to the privacy of your health information. The administrators of the County of Accomack, VA Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Kathy Carmody - CHRO at 757-787-5710 or kcarmody@co.accomack.va.us.

HIPAA Special Enrollment Rights

County of Accomack, VA Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the County of Accomack, VA Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Kathy Carmody - CHRO at 757-787-5710 or kcarmody@co.accomack.va.us.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from County of Accomack, VA

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with County of Accomack, VA and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **County of Accomack, VA has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current County of Accomack, VA coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current County of Accomack, VA coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with County of Accomack, VA and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through County of Accomack, VA changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

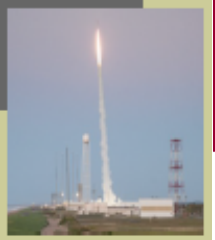
Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**June 01, 2025**
Name of Entity/Sender:	**County of Accomack, VA**
Contact—Position/Office:	**Kathy Carmody - CHRO**
Office Address:	**23296 Courthouse Avenue, Suite 203, P.O. Box 388** **Accomac, Virginia 23301** **United States**
Phone Number:	**757-787-5710**

Pay & Holiday Calendar

January 1
New Year's Day
January 20
MLK Jr. Day
February 17
George Washington Day
May 26
Memorial Day
June 19
Juneteenth
July 4
Independence Day
September 1
Labor Day
October 13
Columbus Day & Yorktown Victory Day
November 4
Election Day
November 11
Veteran's Day
November 26
1/2 Day for Thanksgiving
November 27
Thanksgiving
November 28
Day after Thanksgiving
December 24
1/2 day Christmas
December 25
Christmas Day
December 26
Day after Christmas

Source: As approved by the Accomack County Board of Supervisors, at their August 21, 2024 meeting.



Denotes Payday

Denotes Holiday

Denotes Time Off (1/2 Day)

ACCOMACK COUNTY *Virginia*

2025

January

S	M	T	W	T	F	S
			1	2	3	4
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12	13	14	15	16	17	18
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26	27	28	29	30	31	

February

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March

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30	31					

April

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May

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June

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29	30					

July

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27	28	29	30	31		

August

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31						

September

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28	29	30				

October

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26	27	28	29	30	31	

November

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30						

December

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	1	2	3	4	5	6
7	8	9	10	11	12	13
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28	29	30	31			

IN CASE OF WORKPLACE INJURY:

ACCION a seguir en caso de un accidente en el trabajo

COMPANY NURSE

Injury Hotline

1-888-770-0925

AVAILABLE 24 HOURS A DAY

1. **Injured worker notifies supervisor.**
   Empleado lesionado notifica a su supervisor.

2. **Supervisor / Injured worker immediately calls injury hotline.**
   Supervisor / Empleado lesionado llama inmediatamente a la línea de enfermeros/as.

3. **Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.**
   Profesional Médico obtiene información por teléfono y asiste al empleado lesionado en localizar el tratamiento médico adecuado.

EMPLOYER NAME (NOMBRE DE COMPANIA)	*GROUP CODE (CÓDIGO DEL GRUPO)*
Vaco Risk Management	VACO

Notice to Employer/Supervisor:

Please post copies of this poster in multiple locations within your worksite. If the injury is non-life threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site when possible.

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